BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

# A STUDY OF
# FAMILY CASEWORK IN THE CHILDREN'S MISSION TO CHILDREN

A Thesis

Submitted by

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(B.S., Simmons College, 1920)

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In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1948

School of Social Work
Sept. 21, 1948
2163

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## CHAPTER I

## THE PURPOSE AND SCOPE OF THE STUDY

For several years, the members of the staff of the Children's Mission to Children, a medical child-placing agency, have been giving consideration to the question of whether or not casework in the agency should be restricted to the problems directly related to the children under care, either in foster homes or supervised in their own homes, or whether they should also give casework service in the children's families in such areas as marital friction, budgeting, housing, problems with in-laws, unemployment, and so forth. This question was the subject for discussion at a recent staff meeting to which an executive of the Family Society of Greater Boston was invited, and further meetings are planned to continue exploration of the matter. It would therefore appear to be timely and eminently worth while to analyze the situation in the agency with a view to presenting factual material on which sound conclusions may be reached that would aid in determining the policy of the agency for the future.

## The Problem

The underlying question seems to be, should the Children's Mission as a child-placing agency also provide casework service in connection with family problems which are not related to the child's illness. Subsidiary questions would be, under what circumstances and in what areas. It would also be well to ask when might it be preferable for the agency to refer a case to a family agency, or collaborate with a family agency, and under what circumstances might this be inadvisable.

## Outline of the Study and Its Limitations

A study of the previous practice of the agency will be made to aid in working out the answers to these questions. There will be presented first a history of the agency, emphasizing primarily the development of its present policy of intake: namely, accepting convalescent children for care. There will then be a discussion of the different types of care given children, either supervision in their own homes or placement in foster homes. Since, during the past few years, between 90% and 100% of the cases have been children with medical problems, and between 60% and 70% have been victims of rheumatic fever, it will be necessary to discuss this illness, its care, and its relation to family problems. Following this, there will be an analysis of certain selected cases, with a detailed study of a number of cases that illustrate the methods of pro-

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cedure as of that date.

In order that the cases selected might be representative of the work of the agency in recent years, it was decided to use the intake of the year 1944 as a basis of the study. There were several points that needed to be considered before deciding on that particular year. If the year 1947 were used, cases accepted during the last two or three months of the year would not have progressed far enough for any conclusions to be drawn from the casework process employed. The years 1945 and 1946 were not used for quite another reason. In the spring of 1946 at a staff meeting there was some discussion of the value of continuing cases after the child was referred to his own home. At the time there were a number of such cases that were being kept in the workers' caseloads, yet very little work was being done on them, not enough it seemed to justify continuing to count them as active cases. The practice had been for a worker to refrain from discharging a child when he was returned home after being in a foster home. Instead she would continue to consider him a responsibility, and plan to make visits to the home to check on his physical condition and the care he was receiving for the purpose of helping the mother improve this care when necessary, to interpret to the family changes in the child's behavior due to the foster home experience, to try to help the child adjust back into the home which often seemed strange to him after being away a long time, and to see that he

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became closely tied up with a hospital clinic where he would be followed medically. On the workers' cards, and on the agency books this type of case was called "SH," meaning supervised home care. What was actually happening, however, according to the discussion at the meeting, was that due to a feeling of pressure in regard to cases that were being investigated or were being placed or replaced or for some other reason needed a good deal of the workers' time, they were not actually making many home visits on these SH cases. For this reason, it was suggested that an attempt be made to do the interpretive work in regard to the child's illness with the family during placement, and when he was well enough to return home, refer him back to the referring agency for follow up. The Children's Mission would not continue contact after this. This plan was accepted for the most part by the staff, with the result that for about a year there were very few cases carried SH. There has been a gradual return to the practice of carrying cases for supervision after the child has returned home, in those situations in which it seems evident that there will be some real benefit from so doing. Cases accepted during the years 1945 and 1946, therefore, would not show casework typical of that done before that particular time or following it, since cases accepted in the latter part of 1945 and early 1946 were likely to continue into this particular period when no contacts were made in the family after the child went home. For these rea-

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sons the year 1944 was selected as the logical one for study.

It was then necessary to decide on a method of choosing the particular cases of that year that would be of value for the present purpose. Applications made to the agency that were later withdrawn, or on which advice was given, or those referred to another agency because they were not considered suitable for the type of care Children's Mission gave, - these were all eliminated at the outset as having little or nothing to contribute. Only those cases accepted for care were used. Based on experience in the work of the agency, these cases were divided into two groups: namely, those referred for summer placement and those for regular placement. Cases referred merely for summer placement were excluded from the study in view of the fact that it is not the policy of the agency to do any intensive work with the families of the children sent away for summer vacations. An example of this type of case will be presented later to illustrate this point.

The second group was subdivided into four categories as follows: (a) child's health needs special care that a lay person could not give; (b) home is adequate for the child when in normal health but successful convalescence is not possible; (c) a special home situation makes it necessary for the child to be cared for away from home, such as the mother's hospitalization; and (d) long-time family problems.

In order to secure sufficient data on which to make these classifications, the records of all these cases were

examined, using Schedule A in the appendix. Frequently the social worker, in the majority of referrals a medical social worker, making the referral to Children's Mission gave enough information in the social history which she sent, to be able to make the classification. If the material needed was not found there, the investigation made by the Children's Mission worker was read, and occasionally it was necessary to read further in the record to get an accurate picture of the whole situation.

These particular classifications were worked out with the thought in mind that probably little casework with the family would be indicated in the first three groups, and that the cases in these groups could be excluded from the main study. Although in other years there have been cases that would fall into the group in which the child's health needed special care, there were none in 1944.

In order that there might be cases selected illustrating certain characteristic features of the remaining group, (d) that in which there were long-time family problems, this was further subdivided into those cases in which a family society was active at the time of application to the Children's Mission and those in which no family society was active. Under both of these headings further classifications were made which will be discussed in detail later, when the cases are analysed. It was intended when the study was started, that Schedule B in the Appendix requiring a thorough reading of a record, would

only be used for certain cases selected as typical of their particular subdivision of group (d). However, after a number of cases were read, it was decided that neither those cases in the group in which the home was adequate for a child in normal health nor those in which there was a special emergency could automatically be excluded from the study. Also it was felt that examples of these two groups would clarify the total picture. Therefore, Schedule B was used for cases chosen as typical of these two groups as well.

This is not intended to be a statistical study, nor will there be any attempt to evaluate the casework in the cases chosen for analysis. Neither will there be any discussion relating to the broad problem of the advisability of the merging of family and children's agencies.

## CHAPTER II

### THE AGENCY - ITS HISTORY AND DEVELOPING FUNCTION

The first fifty years of the agency, from 1849 to 1899, demonstrated a slowly evolving concept of child care from the original objective which was as follows:

> To create a special mission to the poor, ignorant, neglected children of this city; to gather them into day and Sunday schools; to procure places and employment for them; and generally, to adopt and pursue such measures as would be most likely to save or rescue them from vice, ignorance, and degradation.[1]

During this period, the early idea of keeping children off the streets and out of trouble in the daytime, changed to that of sending groups of children whose homes and parents seemed inadequate, to the Midwest to be adopted. Later, this plan was given up, and temporary "homes" were set up where children might stay pending their being adopted; and again this program was discontinued in favor of the establishment of an institution in which children might live and go to school.

In 1899 there was begun a study of the possibility of using the "boarding-out plan" and by 1907 it became evident that the institution was no longer needed, and the children

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might well be sent immediately to foster homes. By 1914 the following report describes the work of the agency:

> Foster homes are most carefully selected, and are approved and classified as to the special type of child to be received. We usually pay board for those children not old enough to earn their own way, and keep them under our close control. . . . . The maintenance of these children is by far the heaviest item in the annual budget, though the whole number thus cared for this year (301) was less than 40 percent. of the children helped.
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> The remaining 60 percent. were provided for through the Department of Advice and Assistance, without the necessity for us to take them. This department receives all applications (during the year, 363, representing 557 children), makes careful study, diagnoses the case and prescribes the remedy.
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> Almost all who apply ask that the child be received into charge, but it is our plan to contrive that wholesome families be kept intact, whenever possible, and striking at the cause of the difficulty, we aim at its correction.[2]

The year 1914 marked the beginning of what has come to be regarded as the special function of the Children's Mission. Dr. Richard C. Cabot, who was then organizing the Social Service Department of the Massachusetts General Hospital, expressed the opinion that many children had been so long on the hospital wards they were becoming institutionalized, and their recovery would be quicker if they could be cared for in either their own homes or in foster homes, going to the clinics for whatever medical treatment was needed. Although other agencies considered the placement of such children in foster homes would

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By the year 1920, children with medical problems constituted a quarter of the intake, except during the summer when about half the children received needed post-hospital care. As against 185 received into actual care, 486 were given advice and guidance. This latter figure does not include the 208 referred to other agencies.

It is interesting to watch the growth of this specialized service to convalescent children, and at the same time observe that work to prevent family disintegration continued to serve the larger proportion of children. It is of course impossible from the records to determine the relative amount of the workers' time given to these two areas. In the Seventy-Sixth Annual Report in 1925, the work of the agency is described by the General Secretary as follows:

> During the past year we have dealt with 379 applications, representing the needs of 489 children, and in each instance it has devolved upon us to extricate our clients from their entanglements, to see that peculiar needs are met by specialists, and to provide that form of help which we are specially equipped to render.
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> vided for 233 children, of all ages, and of race and faith without restriction. Here their parents have visited them and we have encouraged return of the children as soon as we were sure that the conditions of both child and home would warrant such a course.
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> Our methods, in brief, are as follows. First there is an exhaustive study of the situation and of the child, with object, the correction of the difficulty without the removal of the child. If the child must be removed we take great pains to select from our approved and classified foster homes, one, of the faith of the child, which just fits the peculiar need. Next comes the placement of the child in its new environment with as little disturbance as possible. Then follow weeks, months, or years of oversight by a devoted visitor, who assumes the function of a guardian of the child and friend of the family, which may itself need rehabilitation. This continues until some time after the child, with the handicap removed, has returned to his own kin.[4]

In this same report, Mr. Field stated that at this time "somewhat over one-third of our children" are of the type with whom the agency specialized; that is, "the child who, after treatment in the hospital, would return to his own home if conditions were suitable, but who, to insure recovery," needed the agency's peculiar form of care. It was in this year, 1925, that the Children's Mission began caring for children with heart trouble. This work was begun with great caution, because the results of care were felt to be problematical. By 1926, the percentage of convalescent children had increased from 33 to 40.

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Another special interest developed, that of working with so-called "problem children." During the years 1927 to 1930 a psychiatrist was on the staff, but due to lack of funds it was necessary to discontinue her services. In the following year, the agency cooperated with psychiatric agencies in the community in the care of twenty-seven children referred solely because of maladjustment and emotional instability. This special service is not mentioned in the reports following 1931.

Gradually the proportion of children under care for medical reasons increased, until by January 1, 1938, the figure 73% had been reached, 56% of whom were suffering from rheumatic fever, rheumatic heart disease, or chorea. During the following year there were 242 children in foster homes, according to the annual report, but 256 children had been supervised in their own homes or elsewhere, advised, or transferred to more appropriate agencies.

One of the objects of the Children's Mission as stated in the Annual Report for 1933-34 was, "Readjusts, if possible, difficult home conditions, to enable children to remain with their own families." For several years, no specific purposes were stated in the reports. By 1939 the objects were given as follows:

> The Children's Mission provides care for children with medical problems from Boston and from any District outside Boston where distance does not make this service impracticable.

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> The Children's Mission provides care for children with medical problems from Boston and from any District outside Boston where distance does not make this service impracticable.

> Owing to limitation of resources, The Children's Mission is obliged to select carefully those persons most needing help and falling most suitably within its function. It does not limit intake on basis of ability to pay for care except in times of great financial stress.
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> This Society particularly serves the hospitals, caring for children with promising medical and social outlook. Medical supervision is maintained in part by the hospitals, in part by The Children's Mission.
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> It provides case work services for children within their own family group, in foster homes, in other institutions, and maintains Study projects which will add to insights and methods in the care of children with medical problems.[5]

From a study of the annual reports for the last few years, it would seem that these objects as stated above are still accepted.

To summarize briefly the developmentof the function of the Children's Mission over the last 100 years, it would appear that in the early years, day care for children was provided, then children were placed for adoption; later, foster home care was secured for children whose own homes were considered inadequate, but only if their own homes could not be made suitable for them; and finally, care of children with medical problems, which at first covered only a small group under care, became the primary function of the agency. It is apparent that, at least by 1914, there has been a great deal of emphasis on working with the child's family in order to prevent the

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## CHAPTER III

## THE NEEDS OF CONVALESCENT CHILDREN

The type of care developed by the Children's Mission evolved because of the needs of the cases referred to the agency. As has been previously stated, more than half of the children under care in recent years have been convalescing from rheumatic fever. This disease has just begun to receive the national attention it deserves as the Public Enemy No. 1 of childhood. Between the ages of five and fourteen years, there are four times as many deaths from rheumatic fever and rheumatic heart disease, as there are from scarlet fever, diphtheria, measles, whooping cough and infantile paralysis combined.[6] In 1945 it was estimated that there were about 200,000 children between five and nineteen years in this country with rheumatic heart disease, and a grand total of between 800,000 and 1,000,000 persons so afflicted.[7] It is now generally agreed that in cases of rheumatic fever it is important to protect the heart, the organ that may become crippled by the disease, by rest in bed, not only during the relatively short acute stage, but throughout the oftentimes prolonged illness until

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[6] Alexander T. Martin, "The Rheumatic Child and Convalescence," Convalescent Care for Children. The National Society for Crippled Children and Adults, Inc. 1946, pp. 78,79.

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all rheumatic activity has subsided. It is further important to protect the individual against upper respiratory infections, since recrudescences of rheumatic activity are usually precipitated by colds and sore throats.

Proper care of children convalescing from rheumatic fever is complicated by the fact that the disease prevails in families with low incomes whose homes are usually not suitable for prolonged bed care.[8] According to Ethel Cohen in an article in The Child, "Epidemiological studies of rheumatic fever, in the United States and England, show a direct relationship between the dark, damp, overcrowded homes and the incidence of rheumatic fever."[9] Long-time bed care is difficult for a child under the best of circumstances. It is too much to expect that a child who may feel perfectly well, will stay quietly in bed while brothers and sisters are playing actively all around, and with a mother who quite reasonably resents the extra burden of care that has been put upon her. Convalescence is made easier and the chances for recovery without heart damage increased, when a child from an underprivileged environment is given the opportunity to have supervised care in a foster home in a group of children similarly handicapped.

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[8] Edward F. Blank, "Rheumatic Fever in Childhood," New England Journal of Medicine, 224, 1941.

[9] Ethel Cohen, "What Rheumatic Fever May Mean to a Child," The Child 11:10, April, 1947, p. 168

all rheumatic activity has subsided. It is further important to protect the individual against upper respiratory infections, since recrudescences of rheumatic activity are usually precipitated by colds and sore throats.

Proper care of children convalescing from rheumatic fever is complicated by the fact that the disease prevails in families with low incomes whose homes are usually not suitable for prolonged bed care.[8] According to Ethel Cohen in an article in The Child, "Epidemiological studies of rheumatic fever, in the United States and England, show a direct relationship between the dark, damp, overcrowded homes and the incidence of rheumatic fever."[9] Long-time bed care is difficult for a child under the best of circumstances. It is too much to expect that a child who may feel perfectly well, will stay quietly in bed while brothers and sisters are playing actively all around, and with a mother who quite reasonably resents the extra burden of care that has been put upon her. Convalescence is made easier and the chances for recovery without heart damage increased, when a child from an underprivileged environment is given the opportunity to have supervised care in a foster home in a group of children similarly handicapped.

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[8] Edward F. Blank, "Rheumatic Fever in Childhood," New England Journal of Medicine, 224, 1941.

[9] Ethel Cohen, "What Rheumatic Fever May Mean to a Child," The Child 11:10, April, 1947, p. 168

Children convalescing from other illnesses, such as nephritis, or those with an orthopedic condition, who need a prolonged period of quiet and supervised care have the same problem that the rheumatic fever patient has, and they likewise, if their own homes are unfavorable for recovery, profit by staying in the same foster home situation.

## Types of Convalescent Care

It is this type of care described above that Children's Mission has to offer. In view of the recent excellent study of foster home care and its use by the Children's Mission, it seems unnecessary to present this subject in detail here, and the reader is referred to the thesis by Frances M. Heald on The Children's Mission's use of foster homes for children with medical problems.[10] It will be sufficient here to summarize briefly this aspect of the work of the agency.

The homes are selected by the homefinder to meet two major needs: medical homes for children who require initially full bed care and who will gradually increase their activity until they can be up and about from six to eight hours a day; and so-called "up homes" for children who can be up at least six hours a day and who perhaps can even attend school. With one exception, the foster parents either own or rent the homes

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for their own use, and the agency pays board for the children placed in their care. The exception is a home recently bought by the agency to be used as a medical home for boys, and a staff was hired to run it. In these medical homes, in addition to the warmth of personality and general reliability sought in foster parents by child placing agencies, it is necessary to secure people who have had more or less experience with sickness in children, depending on the severity of the cases that are entrusted to them.

In the medical homes, in addition to receiving convalescent care, arrangements are made for the children to have home teachers, provided by the town or city according to statute.[11] One member of the agency staff is an occupational therapist, who visits each medical home twice a week, providing material suitable for the children and supervising its use. She also arranges for occasional programs of entertainment. Visiting hours in the medical homes are restricted to one afternoon a week, and only two adults are allowed at a time, in order to avoid over-excitement of the children. Occasionally exceptions are made in the case of parents who are obliged to work on the visiting day, and they are allowed to go at another time. A laboratory technician visits periodically to take throat cultures and blood specimens, and urine specimens when

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necessary. The medical director of the agency visits once a month to make a thorough examination of each child and modify directions for care. He is always on call, and if for any reason he will not be available at certain times, he leaves with the foster parents the name of a substitute physician.

No hard and fast lines can be drawn between medical and up homes, either in requirements for personnel or in the program. The chief difference lies in the fact that the medical supervision of the children remains with the referring hospital instead of being transferred to the Children's Mission medical director, although he is always available in an emergency for consultation. For the most part the routines in the up homes are more flexible, depending on the needs of the particular children placed there at the time. Some children may be very much restricted in activity and require a careful routine, while others may be able to live normal lives and are continuing in placement as a preventive measure. To aid in giving the proper care for rheumatic fever cases, the medical director has prepared some directions for foster parents, as well as general information concerning the disease. This is given in full in the Appendix.[12]

Another type of care given by the Children's Mission is that called "SH" indicating supervised home care. A descrip-

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tion of this has been given in connection with continuing contact with a child after he has returned home. Occasionally a child is referred for placement during convalescence, and upon investigation it is found that it would be better for the child to remain in his own home and the parents given interpretation of the care necessary for him to regain health. This care is also called "SH."

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## CHAPTER IV

## ANALYSIS OF CASES

During the year 1944 there were 235 applications made to the agency, and of these 191 were accepted for investigation. Each of the 191 were investigated by the worker assigned to the case and as a result of the investigation, sixty-four were either withdrawn by the parents of the child or by the referring agency, or were considered unsuitable for Children's Mission by the worker. Five were still pending in January 1945. Of the 122 remaining cases which were accepted for foster home care, forty-four were for summer placement only.

### Summer Placements

In order to show why it is logical to exclude the group of cases referred for summer placement, an explanation should be given of the customary method of handling them, and a typical case presented.

Children are referred, usually by medical agencies, with the request that they be given four to eight weeks of summer vacation. Regular camp placements are not advisable because these children are limited in activity, due to some physical handicap. By far the majority are referred either following

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recent active rheumatic fever or having a history of that disease. They need careful supervision to prevent over-activity and it is hoped that a summer with good hygiene will give the child resistance to upper respiratory infections in the following winter, and thus help prevent a recurrence of the disease. These children are usually referred in the spring, and placements are sometimes in June, but usually in July, and occasionally just for the month of August. Definite plans for each child cannot be made until most of the referrals are in, as the attempt is always made to place children together who will be congenial because of similarity of interests as well as of restrictions. Also, as in any foster home placement, the personalities of the foster parents must be considered in relation to the dispositions of the children. In view of the fact that a worker is arranging for the placement of a number of children in a relatively short time, it has not seemed advisable to go into the home situation with the idea of helping to modify it. Casework is done in the areas of interpreting placement to the child and to the parents, helping children who are closely tied make the break from their family, and giving the foster parents sufficient information about the child's personality, family relationships, interests, and of course specific directions for physical care, so that they can understand and help the child with those problems that may arise. During placement, sufficient contact is maintained with the parents to al-

leviate any worries they may have about the child's care, and the foster mother is given whatever help and support is needed to carry her over the difficulties that do occur.

A twelve-year-old girl was referred on 5/9/44 by the Robert B. Brigham Hospital for summer placement. The diagnosis was rheumatic heart disease with mitrol stenosis, rheumatic fever and secondary anemia. The prognosis was not very good. She should not have too strenuous activity, a rest period of one hour or more during the middle of the day and early bed hours. "No running" was specified. Medication included vitamin B complex, Navitol and Feosol.

The family consisted of mother and father and nine children ranging in age from fifteen to nearly two years. The mother was expecting a baby in October. The father had just gone back to work after a period of receiving relief from the public welfare department because of ill health. The boy of fifteen had just secured a job for the summer.

The hospital social worker was told that Children's Mission would consider placement, and was asked for a social and medical history. These were sent around the middle of June. Listing the case with the Social Service Index revealed that nine agencies had been called in to help the family, ranging over a long time. The Family Society had been active in 1943 and again in 1944. It was learned from telephoning the Family Society that they had had brief contacts only, the first in connection with the boy getting part-time work, and the second in trying to help the father get work. Two home visits were made by the Children's Mission worker after the histories were received, as apparently it was felt the mother was not in a condition to go into the office for an interview as is usually done. When the girl was seen it was decided she would fit into a group of three other girls of about the same age for whom plans had already been made.

The four girls were placed together on 7/10/44 after being seen by Children's Mission physician as a precaution against their carrying communicable diseases. Two weeks later the mother was taken by the worker to visit as the foster home was at some distance from Boston. Things seemed to be going well at home accord-

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ing to her.

During placement the girl learned to be a good sport about losing in games, and learned to enjoy housework and to do it well. It was felt her lack in both these areas was due to her many periods of ill health. The worker was called in to help in an unfortunate situation where the girl had been responsible for breaking the foster mother's watch.

A home visit was made to inform the mother of the date of the return home. At this time the family situation was bad again; the father was ill and out of work and the mother sick from the heat. The child was taken home on 9/1/44. She was seen at the hospital clinic on 10/6/44 and found to have improved in health.

This case contains elements found in many of those referred for summer placement. The needs were typical: supervision to prevent over-activity, plenty of rest, and in general a good healthful regime. Four girls were placed together, all with similar restrictions, in a foster home in the country. Parents visited only once or twice during the vacation. The foster mother helped with a personality problem which seemed likely to interfere with the girl's acceptance by this group, or any group, and taught her some useful skills. The worker maintained contact with both the foster home and with the own home. The child's health improved. This illustrates quite well that all the casework was in connection with the child and the placement process. Although there were economic and health problems in the family, in accordance with the usual agency policy where summer placements were concerned the worker did not attempt to give any active help. This would seem to justify the exclusion of the forty-four summer cases from

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this study.

## Classification of Cases

Eliminating the forty-four summer cases from the 122 cases which were accepted for foster home care in 1944, there were seventy-eight remaining. Of these it was necessary to exclude thirteen from the study because of different reasons: in ten the treatment had not been dictated; one came from out of the state and the home situation was not investigated; one did not have in the record the information necessary as a basis for classification, and one was marked "confidential."

The original classifications set up for this study as described in Chapter I were perhaps too finely drawn, in the light of what was found. It would have been simpler to have divided the cases into two groups: namely, those in which the family functioned adequately, needing help only in special emergencies, and those cases, most of which had been known to a number of agencies over a period of years, in which there were long-time family problems. However, following out the original plan and using four classifications for the sixty-five cases used in the study, it was found that there were none in which there was a health problem needing special care, seventeen in the group in which the home could be considered adequate for a child in normal health, six in the group where placement was necessitated by a family emergency, and forty-two in the group having long-time family problems.

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In one respect the original plan for the study was changed. It seemed advisable to include, rather than exclude those groups in which the family normally functioned adequately, as it was found that in some instances casework with the family was indicated, and it would be well to consider what the agency policy was for handling such situations.

### Groups (B) and (C): Families Normally Functioned Adequately

Within that group of seventeen cases which were referred because the home situation was not suitable for prolonged convalescence of one or more of the children, although under ordinary circumstances it was adequate, classified as group (b), there were two situations that appeared in ten of the cases. In the other seven, there was a variety of reasons given for referral. The first typical situation was that in which the mother worked outside the home and there was no one available to supervise the care of the child during the day, and the other situation was that in which the mother could not keep the child on bed rest, either becauseof the relationship between her and the child or because there were a number of small, active children in the home or in the immediate neighborhood who quite thoroughly interfered with any program of rest and quiet. The following illustrates the first type.

> Case B1 was that of a seventeen-year-old boy, referred by the Massachusetts General Hospital on 4/11/44 with a diagnosis of epilepsy, secondary to brain tumor following a pneumoencephalogram. He needed two or three

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Case B1 was that of a seventeen-year-old boy, referred by the Massachusetts General Hospital on 4/11/44 with a diagnosis of epilepsy, secondary to brain tumor following a pneumoencephalogram. He needed two or three

weeks' placement to regain his strength. Because of the possibility of seizures it was not thought wise for him to remain at home alone while his mother was working. Also, the mother was near the breaking point from worry and the previous care given the boy, and should be free of responsibility for a short period of time.

The boy had been adopted in childhood and was devoted to the adoptive mother and she to him. The adoptive father had died recently, leaving the two in greatly reduced circumstances. The boy worked when his health permitted and he and the mother pooled their resources.

Placement was carried out very quickly. At the end of fifteen days the boy was discharged to his mother as she had started working nights, so could be with him during the day.

Although it was recognized that there might have been some unhealthy aspects in the relationship between this boy and his mother, no attempt was made to go beyond the referring problem which was met satisfactorily.

Following is another case illustrating the problem created when the mother worked.

B2 was the case of a fifteen-year-old girl with convalescent rheumatic fever, whose mother worked. The request from the Boston City Hospital on 8/3/44 was for one month's placement with supervision, as the girl would not follow instructions for limited activity with only six hours up a day. It was found that she was not staying in bed as much as the doctors thought necessary to prevent heart damage, and she was going over the two flights of stairs to the apartment as she pleased. The older sister was married and away from home, and there was no friend or relative who could supervise at home.

Placement was arranged on 8/26/44 in an up-home, where the girl stayed until 7/2/45, going to school while it was in session, and going in by herself to the referring hospital clinic for medical follow-up.

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BS was the case of a fifteen-year-old girl with convalescent rheumatic fever, whose mother worked. The request from the Boston City Hospital on 8\3\44 was for one month's placement with supervision, as the girl would not follow instructions for limited activity with only six hours up a day. It was found that she was not staying in bed as much as the doctors thought necessary to prevent heart damage, and she was going over the two flights of stairs to the apartment as she pleased. The older sister was married and away from home, and there was no friend or relative who could supervise at home.

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> In July, she was referred home to her mother, and the case was carried SH for six months. There seems to have been no contact during this period of SH with the exception of one telephone call and one home visit in the last month to take a Christmas present.

It is not unusual to find that, as in this case, although the initial request was for a placement of limited duration, the child continues in the foster home for a number of months or a year. Sometimes the convalescence takes much longer than was anticipated. Sometimes the doctor in charge of the case is so pleased with the evidences of care the child is receiving, he advises that it be continued until really sound health has been established. In other cases it seems inadvisable to interrupt the school program, particularly if there have been numerous breaks before because of ill health. In this case, possibly it was the hope of the hospital worker that the girl would learn the necessity for a careful regime in an up-home in a relatively short time, and then be able to follow it herself at home. It apparently became evident that she needed continued supervision and for this reason remained for a longer time. The central problem was the girl's health, and this was taken care of. Four of the six cases in which the mother worked were kept SH after the children left the foster homes for one month to eight months. In two of these the worker took care of the follow-up visits to clinics and saw that they were tied up with the medical agency. In the other two cases, no follow-up work was recorded.

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The following case is one of the four referred because the mother was not able to keep the child quiet in accordance with medical directions.

> B3 was a ten-year-old boy with a diagnosis of potential rheumatic heart disease, referred on 9/13/44 by the Massachusetts General Hospital because he would not stay quiet for the mother. She had tried "the kind way and the hard way" and he would not follow directions. He needed supervision to prevent overactivity, a two-hour rest period, and a home teacher. The own home was "immaculate and homelike," "excellently furnished," and he had a room to himself. The family consisted of the mother and father, a sister thirteen years old, and a brother sixteen months. They were Greek.
>
> It was not possible to place the boy until 10/11/44 due to the difficulty of getting a home teacher, but he was then taken to a home where there was one other boy similarly restricted. On 12/44/44 there is a note in the record that "activity is still a problem, but foster mother is able to cope with it and to discipline them when they are over-active. She is kind to them in this discipline. Boys are made to feel members of the family. There is a wholesome routine including homework, recreation, good meals, and early bedtime."
>
> Because of the foster mother's need for hospitalization, the boy was referred home SH on 3/27/45. Replacement in another home was considered, but he was getting along so well at home it was not carried out. On a home visit, 12/19/45, it was found that the family were very happy over the adjustment the boy had made. It was felt his placement gave him a great deal of help in learning how to take care of himself, that he had grown up some, and was no longer so difficult in the home. He was discharged by the Children's Mission worker on that date, to continue on a quiet regime in his own home.

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This is a very satisfactory type of placement with almost a fairy-book ending. The foster mother seems to accomplish a miracle, and the worker's contribution is largely in finding

the right home for the right child. The mother probably secured some help by observing the foster mother's methods during her visits to the foster home. The worker apparently did not do any direct work with the mother to help her understand the basis for the boy's attitude toward restraint at home. It may have been, as it sometimes is, that a language handicap made it impractical. The nine months' period when the case was SH does not seem to have contributed anything to the success of the case.

As was stated before, there was a variety of reasons given for referral in the other cases in this group of seventeen. One of these follows.

> B4 was referred on 1/31/44 by the Massachusetts General Hospital. The diagnosis was glomerulo nephritis, and the directions for care were bed rest in a warm, quiet atmosphere. The general family situation was good, but there was the problem of difficulty in keeping the home adequately heated. Moreover, the boy had to share a room with two brothers, sixteen and thirteen.
>
> Placement was delayed until 3/3/44 due both to the boy's resistance to being placed, and to the Children's Mission worker's resistance to foster home instead of SH care. The worker finally became convinced that the house could not be heated even though supplementary fuel were provided.
>
> There was considerable work during placement to help the boy accept the necessity of his being away from home. His physical condition improved slowly, but he finally insisted on going home before the doctor thought it advisable.
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> low-up at the hospital clinic, took the boy to the dentist, saw that a home teacher went in, and later took care of details in referring him back to public school. The worker was called in once in an emergency when the mother's back was injured in a fall. She contacted the hospital in regard to an ambulance, and met the mother at clinic when she went in for X-ray. She was asked by the father for camp information for the younger brother, which she supplied. In March of 1945, the boy became sick again, but this time definitely refused to be placed. When it was felt that nothing more could be done to help in this situation, the case was closed and the hospital so notified.

This family had been able to manage very well. The only agency that had helped them before was the hospital. This particular illness presented a problem with which they could not cope successfully. The improvement in health during placement was not sufficient to ward off a recurrence when the boy returned home. It was not possible to help him accept the fact that he had a disease for which a particular kind of care was indicated. The family could not be helped to move to a more suitable location. All they were willing to accept from the worker was a limited amount of manipulative casework.

The remaining cases in this group were the following: two sisters placed in a medical home, one for chorea and the other for rheumatic fever following a stay in the hospital, because the mother resented the illness and did not give good care at home; one infant, an exception to the general policy of intake, taken because the mother could not stand the sight

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of the baby's deformity - an external bladder; an eleven-year-old boy with a diagnosis of convalescent rheumatic fever who was not improving at home although his care seemed to be good, and it was thought a change of environment might improve his condition; one little five-year-old girl, also convalescing from rheumatic fever and needing absolute bed rest, who was staying in bed all right, but she was demanding such constant attention the mother could not stand the strain; and another little girl with a diagnosis of bronchiectasis who needed a period of convalescence away from home until adequate heating could be provided for the house.

Four of these six cases just briefly summarized were kept SH following referral home for periods of two to eight months. Of the latter one the worker wrote in the closing summary: "Worker made no home visit after boy returned home because she felt it was not necessary - that she knew the home situation and also that mother would call on her if it were necessary." In the two cases kept SH for six months, there was no contact with the home except for one home visit to take Christmas presents two weeks before discharging the children.

Typical of those six cases in which some emergency home crisis precipitated the request for placement, group (c), is the following:

C1 is the case of a six-year-old boy, referred on 4/26/44 by the District Service of the Boston Dis-

of the baby's deformity - an external bladder; an eleven-year-
old boy with a diagnosis of convalescent rheumatic fever who
was not improving at home although his care seemed to be good,
and it was thought a change of environment might improve his
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C1 is the case of a six-year-old boy, referred on
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pensary, because of the need for bed rest following acute rheumatic fever. The home was described as adequate, but the mother was pregnant and expecting confinement within three months. A further emergency developed when the father had to give up work due to an upper respiratory infection.

The boy was placed on 6/8/44, and made such good progress that he was referred home on 9/6/44. The baby arrived the latter part of July. The Children's Mission provided the layette because of the father's unemployment and consequent lack of income, when other resources failed.

The case was kept SH from the time of referral home to 5/21/45. During the first month or two, the worker saw that the boy's dental work was taken care of. The mother managed clinic visits herself. On 3/30/45 there is the following notation in the record: "Worker decides to keep this case open a month or so longer, in case father does not return to work and there may be some other service we may render family." It was discharged on 5/19/45 when the following statement was made: "It is felt that mother is capable of handling any problem which may arise in this household and that she resents outside help or interference. Therefore, as the medical problem is no longer preeminent, it is decided to discharge this case. Boy is still at home with vague symptoms, but mother has been reliable in taking him to clinic and in following directions."

Following is another case in which the Children's Mission was called in because of an emergency.

C2 presents the problem of a nine-year-old boy with spastic quadriplegia, who wore long double braces and walked with crutches, whose mother needed to go to the hospital for an operation. He was referred by the Services for Crippled Children on 3/24/44. A woman could care for the two other children in the home.

The boy was placed three days after the request was made and he remained for one month when he was discharged home.

A similar situation was that in which three children, recovering from whooping cough, were placed during the mother's con-

pensary, because of the need for bed rest following acute rheumatic fever. The home was described as adequate, but the mother was pregnant and expecting confinement within three months. A further emergency developed when the father had to give up work due to an upper respiratory infection.

The boy was placed on 8\8\44, and made such good progress that he was referred home on 9\5\44. The baby arrived the latter part of July. The Children's Aid Society provided the layette because of the father's unemployment and consequent lack of income, when other resources failed.

The case was kept OH from the time of referral home to 5\21\45. During the first month or two, the worker saw that the boy's dental work was taken care of. The mother managed alone with visits herself. On 3\30\45 there is the following notation in the record: "Worker decides to keep this case open a month or so longer, in case father does not return to work and there may be some other service we may render family." It was discovered on 5\15\45 when the following statement was made: "It is felt that mother is capable of handling any problem which may arise in this household and that she resents outside help or interference. Therefore, as the medical problem is no longer prominent, it is decided to discharge this case. Boy is still at home with vague symptoms, but mother has been reliable in taking him to clinic and in following directions."

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firement, since twenty-four-hour homemaker service was not possible, and the children needed care at night as they were still coughing.

Summary of Groups (B) and (C)

The cases presented above were selected as typical of the group of twenty-three (groups [b] and [c] ) in which the families apparently would be able to manage their affairs adequately in all areas except where the physical care of the child, or children, was concerned. This physical care was provided by Children's Mission for the most part by placement in foster homes. In only one case was there much health supervision in the own home. The records would seem to indicate that very little casework was done in the majority of the twelve cases that were carried SH for varying lengths of time following the children's return to their own homes. In one case, aside from services rendered the child during this period, help was given in securing hospital treatment for the mother and in giving advice on summer camps for a sibling. The other instance in this combined group of cases, in which help was given in an area unconnected with the child in care, was the provision of a layette for an expected baby while the child was in placement.

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Group (D): Long-time Family Problems

By far the larger proportion of the cases studied, forty-two out of seventy-eight, falls within the group in which there were one or more long-time family problems. That help had been sought over a period of years is evidenced by the fact that all these families had been known to at least one agency before being referred to Children's Mission, with the highest number of agencies helping at one time or another, nineteen. Eighteen families were known to between six and ten agencies, this representing the medium of the group.

In order to select cases that would be representative, this group was subdivided into the following two classifications: Those in which a family society had the case open at time of intake at Children's Mission, and those in which no family society was active at that time. By "family society" is meant those agencies whose function it is to work with the family unit, and includes the Catholic Charitable Bureau, the Boston Provident Association, and in one instance the International Institute, in addition to those agencies in which the word "family" appears in the name.

These classifications were further broken down into smaller categories. Under the first classification there were three subgroups: cases referred by a family agency; those in which Children's Mission and the family agency cooperated; and

those in which there was no contact between Children's Mission and the family agency during treatment. There were five subgroups in the second classification: those in which no family society was active during Children's Mission contact or before; those that were in the same situation, but were receiving Aid to Dependent Children; those cases in which at one time a family agency had been active, but the record had recently been closed; those referred to a family society by Children's Mission; and one in which a family society became active, source of referral not known.

The following outline shows these subgroups and their relationships.

Group D

Long-time Family Problems

| | | | |
|---|---|---|---|
| Subgroup I | Family society has case open at time of intake | | 13 |
| | 1. Referred by family society | 4 | |
| | 2. Children's Mission and family society cooperate | 6 | |
| | 3. No contact between the two agencies during treatment | 3 | |
| Subgroup II | No family society active at time of intake | | 29 |
| | 1. No family society active during Children's Mission contact or before | 12 | |
| | 2. Same as 1. - on Aid to Dependent Children | 5 | |
| | 3. Family society recently closed case | 8 | |
| | 4. Referred to family society by Children's Mission | 3 | |
| | 5. Family society comes in during treatment | 1 | |
| | Total | | 42 |

## Subgroup I

### Family Society Has Case Open at Time of Intake

D1, a boy of five and a half years, was referred on 1/21/44 for placement by the Metropolitan District Office of the Family Society of Greater Boston. There was a diagnosis of otitis media, with a history of four mastoidectomies. The boy was practically deaf, and a feeding problem. He needed to be in an environment where he would not be continually exposed to colds. The home was warm, but crowded, and he slept in his parents' room. The father had frequent colds and took no precautions against spreading infection.

The family was made up of the father and mother and four children aged eighteen to four and a half. The two oldest were daughters of the first marriage of the mother. The parents did not marry for love; father wanted a home and mother needed father's earnings. Father drank to excess and showed extremely unpleasant behavior. There was much marital friction and mother planned to separate, taking the children to another home as soon as she could find one.

The plan made between agencies at the time of placement, 4/18/44, was for the family society to continue work with the mother, and if possible the Children's Mission worker was to get father's point of view. During placement, the child developed well, learned better habits, and showed none of the behavior problems expected, such as temper tantrums. On 6/26/44 the case was transferred to a new worker at the family society, and at that time it was thought the home situation had quieted down. However, on 8/22/44 the mother came to Children's Mission office without an appointment to say she had found a furnished apartment, she was selling the furniture to secure funds, and she was planning to place the younger brother in the same foster home with Children's Mission client. It was pointed out that she could not do this legally without father's consent.

On 8/30/44, the child was referred to mother SH, a technicality really, as she had already gone ahead with arrangements to place both children privately in the Children's Mission foster home. Because she

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was so vague and confused at that time, and apparently not capable of planning rationally, the worker suggested to her that she go to the family society for an interview, and the mother agreed. When the worker telephoned the family society worker to arrange an appointment, the latter preferred to wait until mother herself made the appointment, since the interview was not mother's own idea. A few days later, family society was contacted, but mother had not sought help and they were closing the case.

On 12/31/44 the child was discharged to the mother. No contact had been made with her during the four months of SH.

A definite plan was made here, in which the two agencies settled the role each was to play. The change of worker in the family agency seems to have been the point at which the plan broke down and the tie with the mother broken. When she came to the Children's Mission worker in a greatly disturbed state of mind, she was not concerned with the agency procedure but with her own pressing needs. The Children's Mission worker seems to have felt bound by the original plan which unfortunately was no longer functioning. This case presents the very real problem that arises when the client does not follow the rules of the game as laid down by the agencies. Perhaps the worker was also troubled to know just what her role should be in this emergency. It might be that, in a situation like this, the worker would be justified in trying to clear procedure for the client and then let her make her own choice as to which agency she preferred to work with. If she had chosen the Children's Mission, the family society would have understood. If she had decided she preferred to go on with the family

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society, she herself could have telephoned for an appointment. She might have decided she wanted to work things out by herself, in which case she would not have been receptive to any help. On the other hand, in this particular case, the mother may have been too disturbed to make decisions and needed an authoritative person to step in to direct things temporarily.

> D2 is the case of a ten-year-old girl referred by the Boston City Hospital for complete bed rest because of rheumatic fever with rheumatic heart disease. The home was on the first floor in a housing project; it was comfortably and attractively furnished with the bare necessities and the standards were normally good. The parents were convinced that the noise of children just outside their windows, and the two small children in the family, made the girl's convalescence at home difficult. Also, the mother was pregnant.
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> There was conflict at home due to the mother's difficulty in accepting the fact that father was unemployable because of a physical handicap; her family disliked him and tried to persuade her to leave him; the mother was easily upset in dealing with the children and at one time wanted to have them all placed. She herself felt the need of help. She was receiving Aid to Dependent Children and also money through her husband's disability pension.
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> Shortly following the placement on 10/10/44 in a medical home, a conference was held with the worker of the Catholic Charitable Bureau who was active in the family situation, the purpose of which was to discuss (1) the child's relation to her family, particularly her mother, and factors in the parents' personalities which may have had an effect upon her behavior; (2) the province of the Bureau in the case and that of the Mission, taking into consideration both the function of each agency and the needs of the mother and the child. The decision was that the Bureau would work with the mother, and during the process try to get information concerning the child's early years that might be pertinent to the regressive

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behavior she was showing in placement; worker would give such information to the Mission worker and the latter would do likewise with any clues obtained from the child.

During the nine months' placement there were eleven contacts between the workers in the two agencies, including one conference. The behavior problems of the child were worked through successfully with the help of the foster mother. The mother refused psychiatric referral, feeling she was getting sufficient insight to carry her.

The child was referred SH to parents on 7/26/45 and was discharged on 12/31/45. There was no contact with the family during this period except for a home visit to take a Christmas present. One contact with the Bureau was to notify the worker of the child's return home, and the other to say the case was being closed. They had already closed the case in August as the family was getting on very well.

The reasons given in the referral in this case might have indicated in should have been considered under groups (b) and (c) as the precipitating factors making placement desirable were the confusion of small children playing around, and the mother's pregnancy. The family discord, however, was an integral part of the situation, contributing to the need for placement. This case illustrates admirably the possibility of close cooperation between two agencies. With the Catholic Charitable Bureau already in good relationship with the mother, there was no need for Children's Mission attempting to make a close contact with her. Even the material usually secured about a child from the mother during the investigation, was not asked from her by the Mission worker, in order not to interfere with this other established relationship. The frequent contacts between the two

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The following case is typical of those cases in which casework does not seem to be effective in helping the family mobilize its forces to function at a higher level. The question always arises as to the wisdom of doing a purely manipulative piece of work in an attempt to improve the health of the children.

> D3 was referred by the Robert Brigham Hospital for bed rest and the usual convalescent care following an attack of rheumatic fever. He was a six-year-old boy, one of a family nine children ranging in age from thirteen years to one year. The home was sub-standard, damp, crowded. The father worked irregularly and the mother gave inadequate health supervision. Both the Family Society of Greater Boston and the Boston Provident Association were among the five agencies who had been active in this family.
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> Following placement on 7/14/44 in a medical home, there seems to have been little contact with either the boy or the family. Convalescence was unusually rapid, and he was referred home SH on 8/31/44. There was still no contact with the family, nor with the family society until December of that year when the Mission worker made a home visit to give $15 from a special fund for Christmas. It was found at that time that mother was pregnant, and no preparations had been made in this connection.
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> First contact with the family society was made on 12/21/44 when it was found the family had been referred by the visiting nurse. The family society worker said she would remain in the family until the pregnancy was over, would arrange for housekeeper, and so forth. During two contacts the fol-

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lowing month, the family society worke r "assured the Mission of their wish to help out in any way that might arise in the future of this family."

Children's Mission work during the eleven months that the case was kept SH consisted in supervising the boy's dental care and clinic visits, and in getting two of the siblings to clinic. Plans were made for summer placement of two children, but at the last minute they refused to go. $20 was given for relief.

When the case was discharged on 7/24/45, the family society was so informed. The worker said she was active with the family and hoped to get a new house some way or other for them. If health reasons made it imperative, she would contact the Mission.

The case was reopened in connection with another child, and in the course of the investigation, the family society was telephoned on 1/17/46. They had closed the case on 9/29/45. The new family society worker stated it was felt all this family wanted from them was financial assistance. It was recommended to mother that she apply through St. Vincent de Paul for a regular supplementary income of perhaps $5 a week.

This case is still active with Children's Mission, the twins having been in placement during the past year, one because of a recurrence of rheumatic fever following pneumonia, and the other for post-operative care following two mastoidectomies. There are now five children in the family with rheumatic Heart disease and there has been a question of rheumatic fever in the two youngest members. The approach to this case has varied over the past four years, depending on the point of view of the worker assigned to it. As has been shown, the first worker gave supportive treatment and did manipulative work. The next worker, a student, attempted to give the mother some insight into her own motivation in accordance with the interpretation

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given the case by the field guide. Referral to family society was not successful, for the reason given above. The Children's Mission worker assigned to the case when it was referred for the third time, held the point of view that the agency should not invest time and money in this family unless the parents were willing to share actively in placement and indicated some acceptance of casework. This time, the child was not placed, although the referring hospital believed foster home care was necessary to insure his return to health, because neither parent would go into the Children's Mission office for an interview. This had not been insisted on in the previous placements. The present worker recognizes that the parents do not wish casework directed at helping them work through their personality difficulties. However, there is the reality situation in which twelve people are trying to live on an income approximately half of the minimum budget of $90 a week based on the Visiting Nurse Association figures. Why the mother had so many children, and why the father is frequently unemployed are questions that perhaps should be answered, but the actual situation remains. The children will continue to be a source of great expense to the hospitals called in to take care of them when they get sick. There is the chance that several may become public charges when they are older as a result of being physically handicapped with heart disease if they have any more attacks of rheumatic fever.

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Plans were made for a conference of all the workers concerned with this family, including the worker from the Department of Public Welfare, since they were frequently called in when the father was out of work. The idea of this conference was then presented to the mother for her consent. She was told the purpose was to try to arrange for continuing supplementary income as long as there was such a discrepancy between income and need. After thinking it over, the father refused to give his consent to the conference for two reasons; first, because of previous experience he was sure no supplementary income would be forthcoming, and second, because he was afraid if such help were provided, the family expenditures would be constantly supervised and he did not believe the mother could stand such interference. The present worker's purpose is to continue in this family even after both children are returned home in order to see that clinic visits are made by all the members of the family, and to give the mother the support she seems willing to accept. Relief is being given in the form of clothing to all members of the family.

The question of course arises, how many families of this type could and should an agency carry? The answer would seem to depend on several factors. A firm relationship between the family and the worker is essential. If frequent visiting in the home is going to be necessary, as well as spending time at clinics, the accessibility of the home will have to be consid-

ered. Thought must also be given as to whether or not such active supervision will actually prevent serious health problems from arising, with their consequent need for large expenditures of the community's money.

The three cases in which the records showed no contact between agencies, although a family society was apparently holding them open, represent two families. In both these families there was severe marital discord, the parents were limited mentally, the fathers drank heavily. The children's health improved in foster homes, but there seems to have been no attempt to help in these severe family problems.

Subgroup II

No Family Society Active at Time of Intake

D4 and D5 were two sisters, aged 8 and 9, one with a question of rheumatic fever and the other with symptoms that had not been definitely diagnosed. They were referred by two different agencies. D4 was already under care at the Sharon Sanatorium, and Children's Mission was asked to provide the casework necessary both with the child and in the home as there was no social service department at the Sanatorium. The mother needed help in working out a satisfactory plan for the child following her discharge. D5 was referred for placement by the Massachusetts General Hospital for observation to determine if the basis for episodic upsets was emotional. The mother and father were separated, he being in the Seebees. The mother worked although she had severe spinal trouble and had to wear a special girdle, because she could not bring herself to accept public relief.

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was helped to get a divorce and accept hospitalization. There were several cases at one time, when children already in the Sharon Sanatorium for treatment of rheumatic fever, were referred to Children's Mission for supervision, as in the case of D4 above. It was expected that the Mission would carry financial responsibility as well as help the family work out whatever problems there might be in connection with the child returning home. One reason for having a social worker active in the family was that the children might be placed on sulpha therapy which entailed the necessity for following a pretty rigid routine of medication and clinic visits. Apparently it was felt that the experience of the Children's Mission with rheumatic fever victims justified the referral of children to that agency, although usually no placement was involved, instead of to a family agency.

The following is typical of those cases in which no family society was active, that present a picture of substandard living with no apparent desire on the part of the parents to improve their conditions.

> D6 was a girl of twelve referred by the Boston City Hospital for bed care with slow increase in activity, following an attack of rheumatic fever. The home was a second floor flat in a damp tenement in a poor section of the city. It was noisy because of many children in the neighborhood. The girl slept with two sisters. The family consisted of mother and father and five children, aged sixteen to eight years. Three agencies had previously been active. There was a problem never fully understood which involved keeping certain secrets from various members of the

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> family, and the child was in the midst of this situation.
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> During the eleven months of placement, the girl learned the principles of keeping well. Early in placement, the worker tried to help the mother in the area of housing, but the family remained in the unsuitable flat. Interpretation of the care of rheumatic fever was given.
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> The child was referred home SH and was discharged eleven months later. Periodic calls were made during this time and the health continued to be good. The hospital continued medical supervision following discharge.

In this family, the worker was not permitted to share in the problems, with the exception of housing. The mother would dicuss this with the worker, but was not able to make any progress.

Other cases like this, in which no desire is evidenced to improve a poor home situation, are summarized briefly. A boy of eight received eighteen months' care in a foster home, improving medically and emotionally. His parents had separated, and the father was made guardian. He seemed to want no help with his own problems, or with working out future plans for the boy, for he arranged for him to stay on privately in the foster home without considering this with the worker. A thirteen-year-old boy, the third from the last in a family of four sisters and three brothers ranging in age from twenty-two to eleven, was placed for bed rest because of rheumatic heart disease. The family wanted long placement for him, rather than modify their own situation so that he could be

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The group in which no family agency was active, but who were receiving Aid to Dependent Children were considered separately for the reason that the ADC worker does play a role in the family situation, although because of an extremely heavy case load, it is seldom possible for her to do any intensive

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casework. Contact between the Children's Mission and the ADC workers is advisable if for no other reason than to interpret the needs of the convalescent child to the other worker.

D7 was referred by the Boston Dispensary for bed rest following a possible recurrence of rheumatic fever. The primary reason for placement of this eight-year-old girl, as given by the Dispensary worker, was to give both the mother and girl the benefit of casework. Conditions at home, although it was substandard, were not given as the most important reason.

The family was made up of the mother and three children, eleven, eight and two years. The two older ones were illegitimate. The step-father, own father of the two-year-old, had died two years ago. The family was known to nine agencies including the Boston Provident Association, Judge Baker Guidance Center, and the Habit Clinic. The mother had not cooperated well with these last three. She recognized the fact that she had no affection for the girl referred.

During the three months of placement, both the worker and the foster mother helped the child by encouraging her to be more grown up. The foster mother made a point of telling the mother of problems she had with the girl that the mother had complained of, so that mother would not think they were her own fault. The worker had interviews at home with the mother around the questions of marrying the "boy friend," and moving.

The girl was referred home SH on 6/3/44 and the case was kept open until 3/9/45, although it was inactive after the end of two months. The child improved in health at home, and her attitude toward the mother and siblings was better. The mother continued some contact with the foster mother from whom she received considerable support.

The ADC worker was contacted right after placement, but as she was new on the case, felt she had nothing to contribute to the understanding of the situation.

Previous referrals to agencies to help this mother work through her rejection of this daughter failed. She was un-

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willing to cooperate to the extent of keeping appointments. A non-professional relationship with the foster mother which gave her support and encouragement met her needs better. Also, the foster home served as a demonstration center and gave her concrete illustrations of methods to use with her child. This latter point is recognized as one of the most valuable contributions foster home placement can make to increase the parents' understanding of child care. It not only demonstrates sound methods to use in meeting behavior problems, but illustrates graphically the value of a consistent, careful routine in physical care. A large part of the worker's role in this case was interpreting to the foster mother the relationship between mother and daughter, and helping her see the needs of both.

The characteristic difference that these cases showed from the previous group - the twelve in which no family agency was active - was that the father was out of the home. In most instances, he had long been a problem. One father was serving a life sentence, another was in the House of Correction, another had deserted and it was not known whether or not he was dead. The problem of marital friction was eliminated, but there was added to the usual problems of inadequate housing, marginal income, illness, and limited personalities, the children's feelings about their father. In two of these cases the mother was encouraged to move to better quarters. There seems to be little other movement shown in the records.

The following case was selected from the group in which a family agency had been at one time active, but which had recently closed the case.

> D8 was a girl thirteen years old, referred for placement by the Boston City Hospital. The diagnosis was rheumatic fever with rheumatic heart disease, and bed rest was needed. It was felt the mother should not assume care of the girl because of the recent delivery of a baby. The home in this case is not described. The family consisted of the mother, father, and six children aged thirteen years to two months. They had been on the Department of Public Welfare relief rolls, father had a great deal of illness, the mother had rheumatic heart disease, the seventh child had died recently.
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> The Family Society, Catholic Charitable Bureau, and the Boston Provident Society had all been active formerly, as well as eight other agencies. The family society had known the family for about ten years and helped with relief during periods of illness, and had also given furniture. They had closed the case in May 1942. The Boston Provident had provided homemaker service and was not contacted by the Children's Mission worker, nor was the Catholic Charitable Bureau.
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> Placement lasted for six months, during which period there was considerable contact with the father, both in interviews and through correspondence. He brought up the question of placing the brother, aged four, but the hospital did not think he was sick enough to need going to a foster home. He requested summer placement of the boys, but the worker was not able to arrange this.
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> The girl was referred home SH, and for the following six months until the case was closed, there were some contacts in regard to dental work. The girl did not continue the habits of good hygiene she had learned in the foster home.

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Another case which the family society had closed in 1942 follows. Although the whole family situation was parti-

ularly bad, the family society contact had only been brief.

> D9, a nine-year-old boy, was referred by the Boston City Hospital for bed rest and usual convalescent care following an attack of rheumatic fever with rheumatic heart disease. The home conditions were extremely poor; the mother and father and five children aged nine years to one year lived in three basement rooms which were dark and damp. Mother was in her sixth pregnancy, and her health was not good.
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> Placement had to be delayed one month due to risk of contagion following the scarlet fever that had preceded the rheumatic fever. The plan was to move the family if at all possible after the baby was born. The hospital worker had written the Housing Authority in an attempt to get the family into a housing project.
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> During placement, some relief was given the family in the way of money for Christmas and clothing for the boy. Nothing was accomplished in regard to housing. Mother was able to talk freely with the worker about her problems. The boy's health improved and his dental work was done. A tonsilectomy was arranged for him at the hospital.
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> During a home visit, the worker was called upon for advice by the maternal aunt who had an illegitimate baby, and later she was asked to get the aunt a job in a private family. She handled these requests by referring to the Department of Public Welfare, and family society.
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> Since home conditions remained impossible for the boy, he was referred to paternal uncle and aunt SH, and the case was kept open for six months when he was discharged to them. There were frequent contacts with the aunt and mother to try to work out satisfactory arrangements whereby the boy might stay on with the aunt.

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lowing ways: The Catholic Charitable Bureau had been active in one family from 1930 to 1942; they had spent much time and money with little results; in the family in which nineteen agencies had been active, the family society was not able to help in the extremely poor home condition and closed case; and in the third case, the family society closed the case in 1943 with the statement that "mother unable to be worked with." In two of the others, the family society had only brief contact, such as help with budgeting, and did not go into the whole disturbed family picture. In two of these eight cases Children's Mission has stayed in for four years and has gradually accomplished something, but in both cases the children referred for placement have remained out of the homes.

Early in this study, when it was found that the majority of the cases had long-time family problems, the writer expected to find that a number of them would be referred to a family agency, so that the family would continue to receive help from a social agency after the Mission withdrew when it had fulfilled its particular function of bringing the child back to normal health. It was therefore unexpected to find that in only three cases in which there were long-time family problems was a family agency called in. In one case there was a specific request, and the other two were referred with the hope that family casework could help the families function at a somewhat higher level.

D10 was a girl of sixteen referred by the Massachusetts General Hospital for bed rest. There was a diagnosis of rheumatic heart disease, and the girl had not been staying in bed at home. The referring letter described the "house as not a wholesome place for a girl in poor health and is permeated with age and probably dampness; heated by kitchen stove only; toilet in a corridor; girl sleeps with mother; diet inadequate." The family was Italian and included the mother, father, and the one daughter. Three other children were older and away from home. Father did not understand the illness. Six agencies had at one time or another been active, but all at a much earlier date; for example, family society from 1911 to 1930.

The girl was placed ten days after referral. The emphasis in casework was in interpreting the illness and proper hygiene to the family through the older brother and sister who understood English. It was found that the girl had a great deal of fear in connection with some eye trouble, and proper glasses were fitted. The foster mother tried to help the girl learn better methods of housekeeping, tying this in with her desire to get married.

When it was time for the girl to go home, both the family society and the Boston Provident Association were contacted to try to get a bed for her so that she could sleep by herself. The latter agency provided one. She was referred home SH at the end of nine months of placement, and was not discharged for eight months. During this time, the worker accompanied her on two clinic visits. It was learned that she was staying out late at night with a boy friend, but nothing could be done to prevent this, although from a health point of view she still needed plenty of rest.

Since 1944 the policy of both the Family Society and the Catholic Charitable Bureau has become quite fixed in regard to giving relief in a family in which no casework is being done by that agency. All requests of this sort are refused. It is different in a case like the following, in which the agency is asked to help in working out a carefully conceived goal with

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the family and furnishing relief is a legitimate part of the casework process.

Dll was a boy of four, referred by District Service for placement because of rheumatic fever. He needed bed rest and good hygiene, not provided at home. The home was adequate physically, except that it was hard to heat because of high ceilings, but it was usually very dirty. The family was made up of the mother and three boys aged ten to one year. The father was in jail for drunkenness and non-support. The other twin to the year-old boy, a girl, died one month before referral with question of neglect. The mother was of limited mentality, in poor health, incapable of managing the house and children.

Ten agencies had had contact with the family. The Visiting Nurse Association was active, and the mother was receiving Aid to Dependent Children. The family society and the Society for Prevention of Cruelty to Children had closed their records recently. The family society contact was brief in regard to giving relief pending the acceptance of the case by ADC. The SPCC was called in connection with neglect of the infant who died, but this could not be proven because of a difference in stories told by members of the family.

The placement plan was to attempt casework with the mother to try to get the family in order before boy's return home. Placement was made on 6/2/44. Frequent home visits were made for interviews with the mother, principally to talk with her about the foster mother of whom she was somewhat afraid, and to try to get her to visit the boy. He was still in the medical home when the case was transferred to a new worker on 9/17/45. Due to medical complications the boy was referred to the hospital in 11/45, then referred to an aunt SH, to his own home, back to the hospital, then to an up-home where he made a poor adjustment, and finally to another up-home where he got along very well.

During all this changing the mother was encouraged to share in plans and gradually she assumed more responsibility. She was referred to family society who agreed to work cooperatively with the Mission for six months, trying to get mother's health improved and into a better home. The ADC worker was

Ten agencies had had contact with the family. The Visiting Nurse Association was active, and the mother was receiving Aid to Dependent Children. The Family society and the Society for Prevention of Cruelty to Children had closed their records recently. The family society contact was brief in regard to giving relief pending the acceptance of the case by ADC. The SPCC was called in connection with neglect of the infant who died, but this could not be proven because of a difference in stories told by members of the family.

The placement plan was to attempt casework with the mother to try to get the family in order before boy's return home. Placement was made on 8\2\44. Frequent home visits were made for interviews with the mother, principally to talk with her about the foster mother of whom she was somewhat afraid, and to try to get her to visit the boy. He was still in the medical home when the case was transferred to a new worker on 9\17\45. Due to medical complications the boy was referred to the hospital in 11\45, then referred to an aunt SH, to his own home, back to the hospital, then to an up-home where he made a poor adjustment, and finally to another up-home where he got along very well.

During all this changing the mother was encouraged to share in plans and gradually she assumed more responsibility. She was referred to family society who agreed to work cooperatively with the Mission for six months, trying to get mother's health improved and into a better home. The ADC worker was

the family and furnishing relief is a legitimate part of the

casework process.

contacted frequently, and she entered into the plan to give mother support and approval whenever possible.

The boy was discharged home on 5/16/46. He was not kept SH as it was at this time that the policy of the agency had changed in this connection.[13] The mother had been tied up with the family society, with the hospital social worker, and with the visiting nurse who was sent the medical history and asked to supervise the boy's health in the home.

Summary of Group (D)

Long-time Family Problems

The eleven cases summarized above were chosen in order to illustrate typical long-time problems found in families referred to the Children's Mission, and the variety of services rendered by the agency. Certain elements in other cases from this group of forty-two were presented in order to round out the picture of the group as a whole. Many of these families were overwhelmed with the most serious problems of marital friction, substandard housing, inadequate incomes, poor health of one or both parents as well as illness in the children, and so forth.

In thirteen of the forty-two cases, a family society was already active in the family at the time Children's Mission was brought in to deal with a specific medical problem. Whether or not confusion resulted from having two workers in the family depended on the contact maintained between them.

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In the case of D2 there was careful joint planning by the two workers and frequent contacts between them, with the result that there was no confusion either on the part of the mother or the workers as to the area in which each agency was working, and she was helped to make considerable progress in her relationship with members of her family, as was also the child. In the case of D1, although an original plan was made defining the areas in which each agency should work, the family society apparently underestimated the severity of the home situation and dropped out. This left the Children's Mission worker in an uncertain position, and the mother seemed to fall between the two agencies. D3 was another case in which the areas of work were defined and adhered to for a period of time. When a change in policy on the part of the family society made them close the case, this was made clear to the Children's Mission worker, so that she could assume the full responsibility for working with the family.

In the majority of cases in this group, twenty-nine out of the forty-two, no family agency was active at time of intake. In very few cases could it be said that Children's Mission was instrumental in effecting a change either in condition or attitude. However, in most instances, the medical problem that precipitated the referral was well taken care of.

It should be again brought out at this point, that no evaluation of casework is intended in this study. When the

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It should be again brought out at this point, that no evaluation of casework is intended in this study. When the

statement is made, for example, that in very few cases is much change apparent in families with serious problems following contact with Children's Mission, there is no implication intended that more or better casework could have been done. In at least six of the cases it was very evident that no desire for help was shown on the part of the parents, and in three cases the family agencies that had been working with them had already reached the conclusion that they were wasting effort as they could see no progress in the families. It would be unrealistic to suppose that a Children's Mission worker could accomplish a great deal under those circumstances.

There is another angle that should be presented here. Many of the records were written anywhere from six months to a year or more after the events occurred. Many details were undoubtedly forgotten. It would have been practically impossible, unless very full notes were made at the time, to dictate interviews several months after they took place in such a way that the therapeutic values in the relationship between worker and client would be made clear. It is undoubtedly true that the acceptance and support given by the worker had an effect, even though this was not indicated in the record, and probably relief from pressure was secured in some instances when opportunity to talk freely was given.

Specific help was given in a number of instances to meet the individual's needs beyond that directly connected

with the medical problem of the child. This was in addition to the more intangible type of casework described above. This help consisted of cash relief, clothing for both the child in care and other members of the family, and dental work for the child. Advice was given on summer camp for other children in the family, on applying for public relief, and on employment. Through the casework relationship between mother and worker, individuals were helped to reach decisions in regard to moving to securing a divorce, to the acceptance of hospitalization, and in regard to marrying. A case of mother-rejection was partially cleared.

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## CHAPTER V

## FAMILY CASEWORK

In going over the records of the Children's Mission it becomes apparent that there are certain almost universal casework procedures which are directly tied up with the function of the agency; namely, that of helping convalescent children regain sound health either in their own or foster homes. These procedures include interpretation of the disease and the care needed both to the child and to the family; seeing that necessary medical supervision is provided at clinics or otherwise; helping both the child and the family accept foster home placement if that is indicated; giving the foster mother whatever information and support is needed during the child's placement; and tying the child up with the proper agency, or agencies, to see that medical supervision is continued after the case is discharged. To a greater or lesser degree, schooling is supervised, and in this connection a testing program may be arranged; dental work is taken care of; clothing is provided when the family cannot afford it; help is given in developing certain skills; eyes may be tested and glasses provided. If severe emotional problems are found, therapy may be arranged either through clinics or by private psychiatrist. All these services seem to be tied up logically

# CHAPTER V

## FAMILY CASEWORK

with the agency function.

When the worker goes over into the area of housing for the family, supervision of medical care of other members of the family, providing relief in the form of money or clothing for the family, advice on budgeting, counseling in regard to divorce or separation or other legal matters, is this family casework? Is she getting outside the function of the agency?

In this connection it is interesting to note the classification of problems made by the Family Society of St. Paul as presented in an article published in the October 1947 issue of Survey Midmonthly, under the title "Forging New Tools." The fifteen most frequently occurring problems in cases open at some time during the first ten months of 1946 follow:

Difficulties in relationship between husband and wife
Emotional instability affecting personal and family adjustment
Problems of financial planning and home management complicated and/or caused by intellectual or emotional difficulty
Difficulties in relationship between parent and child
Working mother needing advice and assistance in making child care plans
Problems of financial planning and home management caused by lower standards or marginal income
Alcoholism affecting personal and family adjustment
Cruelty or neglect or acute distress of children, alleged or actual
Difficulty in relationship with relatives
Financial need due to lack of support from head of family
Need for help with problems of training and development of children
Need for legal advice and service on problems affecting children--Juvenile Court
Need for legal advice and service on divorce, separate maintenance and annulment

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Cruelty or neglect or acute distress of children, alleged or actual
Difficulty in relationship with relatives
Financial need due to lack of support from head of family
Need for help with problems of training and development of children
Need for legal advice and service on problems affecting children--Juvenile Court
Need for legal advice and service on divorce, separate maintenance and annulment

Illness or handicap affecting capacity for social and industrial adjustment
Problems in relation to housing affecting family life[14]

These are the first fifteen out of a classification of ninety-eight developed by the staff. In only 17.6% of the cases was one of the problems identified alone; in all the rest there were more than one. The median per case for the entire group was 3.11. The maximum was 17. In order to show the multiplicity of problems connected with the central problem of family relationships, a chart was given with the following data: Of all the cases presenting problems of family relationships, in 48.1% there were economic problems, in 36.5% employment problems, in 25.5% physical health problems, in 53.2% mental health problems, in 41.8% social and environmental problems, and in 28.6% legal problems. One conclusion drawn was that "there are definite limits to the soundness and practicability of organizing specialized agencies or specialized programs around particular symptoms or problems, unless that specialty can be related to some diagnostic resource equipped to study the totality of the family's needs."[15]

Another classification of problems handled at a family agency was made in a study of the Family Service Department of the Wellesley Friendly Aid Association in the year 1946. The

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[14] A. A. Heckman and Allan Stone, "Forging New Tools," Survey Midmonthly, LXXXIII:10, October, 1947, p. 267.

[15] Ibid., p. 268.

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[14] A. A. Heckman and Allan Stone, "Porting New Tools," Survey Midmonthly, LXXXIII:10, October, 1947, p. 287.

[15] Ibid., p. 288.

list follows.

Treatment of emotional problems, by agency and/or by clinic or specialist
Financial assistance in the form of supplemental aid, temporary relief, or basic maintenance
Health care including glasses, medical, dentistry, mental illness, hearing aid
Camp placements
Social study of family for other agency
Counseling in the areas of vocation or job, guidance of adolescent girls, adoption, and legal advice
Placement and care of aged, imbecile children, lodging for pregnant woman and child
Friendly visiting to the aged
Housing

Relief was given for camp, psychologist, clothing, dentistry, school milk, medical care, food, gifts, fuel, glasses, development, rest home, housing, rent, tuition.[16]

With experience in a family agency as background, the writer accepts these classifications as typical of the problems handled at family agencies, and casework dealing with these problems may well be called "family casework." Casework with these same problems under the auspices of a child placing agency may still be termed "family casework." It would be apparent that in comparing the types of problems served during the year 1944[17] with the above lists, many are the same. The first question, "Is this family casework?" is answered.

The second question remains: "Is she getting outside the function of the agency in doing this type work"?

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[16] Marion Elizabeth Minard, "A Study of the Family Service Department of the Wellesley Friendly Aid Association, Wellesley, Massachusetts in the year 1946," 1947.

[17] See pages 34 and 59.

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Treatment of emotional problems, by agency and/or by
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16 Marion Elizabeth Hinard, "A Study of the Family Service Department of the Wellesley Friendly Aid Association, Wellesley, Massachusetts in the year 1946," 1947.

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The writer agrees with the conclusions reached by Heckman and Stone that it is unwise to attempt to deal with a specific problem unrelated to the totality of the family's needs. This may have to be done if that is the only area in which the family wants or will accept help. Occasionally it may be possible to segregate problem areas so that two agencies or even more may work together in one family. In the majority of cases, however, and in order to avoid any possibility of confusion, it would seem more practical for the worker in the child placing agency, who must have because of the very nature of her work, frequent contact with the members of the family, to go into any problem areas that are brought to her, and not suffer any pangs of guilt that she is going outside her function.

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# CHAPTER VI

## SUMMARY AND CONCLUSIONS

The purpose of this study was to consider the advisability of limiting the casework of the Children's Mission to Children to the area directly relating to its function of supervising convalescent children either in their own homes or in foster homes, or giving casework services in other areas as various problems were uncovered in the children's families. It was felt that a review of the history of the agency would show what the practice of the agency had been, and that a study of the cases accepted in one year, 1944, would show the more recent practice.

The annual reports of the agency, the most authentic history available, showed that for many years a large part of the work of the agency was devoted to improving the home conditions of the children brought to its attention, in order that they might remain there. The present specialized function did not become crystalized until the 1930's.

In order that an understanding of the specialized work of the agency might be secured, a description of the disease most frequently encountered seemed necessary. Between 50% and 70% of the children under care in recent years were convalescing from rheumatic fever, a disease which requires a long

# CHAPTER VI

## SUMMARY AND CONCLUSIONS

period of bed rest with very slow return to normal activity. To make such a tedious process bearable to a child, great care must be taken to see that the atmosphere surrounding him is congenial, and that he have all possible opportunities for normal mental and emotional growth. There must be at the same time, medical supervision of his physical progress. Special types of care were developed by the Children's Mission in both medical and so-called "up-homes" to meet these needs.

Cases accepted for care in 1944 were studied and classified in order that sample cases might be selected showing characteristics typical of each. Excluded from careful study was the group of summer placements in which the purpose of placement was for the most part supervised activity and general building-up care with the idea of helping the child get through the difficult winter months without a recurrence of the disease. The remainder of the cases were divided into two major groups: those in which the family had been functioning adequately but was unable to cope with the medical problem presented by the child, and those in which there were long-time family problems. It was found that in both groups casework was done by the Children's Mission workers in areas not directly relating to the care of the child referred. These areas included housing, the giving of relief and clothing, medical problems of other members of the family, divorce, employment, and so forth - all problems that are dealt with

in family agencies.

## Suggestions for Future Policy

Any uncertainty in the minds of the caseworkers at Children's Mission as to just what areas of work they may deal with should be cleared away. It seems apparent that sometimes a worker has been blocked when an emergency situation arose, not knowing whether - giving due regard to agency function - this was something she could work on directly or whether another agency should be called in. This would appear to have been true in cases D1 and D10. If a worker has any insecurity in this connection, it would be almost certain that the client would sense it.

Perhaps a good way of reaching a solution to the problem indicated in this study, would be to start at one extreme, and work from that. As a point of departure it can be definitely stated that Children's Mission workers should not do family casework in every case assigned to them. Are there any specific situations in which one can be reasonably sure it would be inadvisable? And what are the possible variations to these that make family casework desirable?

If a family agency is active in the case at time of intake, and it looks as if a good relationship has already been established and some progress is being made, it would seem very unwise for the Children's Mission worker to go into

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the family problems. Based on previous experience, however, in order for this cooperative plan to carry through constructively there should be frequent contacts between the two agencies, at least as often as once a month. Early in the case there should be a conference to consider the situation in all its aspects and to determine the areas of work. The difficulty apparently arises in such an arrangement when one agency changes its mind about a plan previously agreed upon, and does not let the other agency know that a change in policy has been made.

It may happen that a family agency is active in the case, but no apparent progress is being made. For some reason, perhaps because Children's Mission functions around a concrete problem, the client seems to be more at ease working with the latter agency. An objective conference at this point may indicate that the family agency should withdraw, and Children's Mission should go into the whole family planning. The client should be given the opportunity to decide with whom he prefers to work.

If the family has been functioning adequately for a number of years, and the only area in which help is requested is in connection with the convalescence of the child, then it would be clearly indicated that, barring some unexpected emergency, there will be no need for family casework. If however, some situation does arise during the course of place-

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ment with which the family seems unable to cope without help, it would seem wiser for the Children's Mission worker to give whatever casework service is needed, rather than refer the case to another agency. Under the present policy in most family agencies, they prefer not to take short-term emergency cases if another agency is already active. Moreover, if the family has been independent to the extent of caring for its own needs up to the time of referral to Children's Mission, the chances are that calling in another agency, unless it were in a special field such as child guidance, would be an unnecessary blow to the family's pride. It would also be inefficient financially as well as from the point of view of time involved, because of the necessary expenditure of money and time for investigation by another agency.

On the other hand, when it is expected that a child will be in placement for only a short time, such as in a summer placement, and the parent brings to the worker a problem that will take a long time to work through, it would seem logical to make a referral. However, if the child's health is bound up with the problem and a close relationship between worker and client has been established, it might be wiser to stay in the case, supervising the health needs of the child after he goes home while working with the problem. In this type of situation the problem may lie in the client's own attitudes and what he needs is help in working through his emotional conflicts. Ex-

treme care must be taken in accepting this type of problem, because of the inaccessibility of psychiatric consultation to the Children's Mission staff.

When the general family situation is poor, such as in the cases in group (d), yet the parents either have no apparent interest in changing their condition, or actually resist any approach on the part of the worker to some of the problems, family casework is probably not indicated. Theoretically, children are not accepted for care by Children's Mission unless the social as well as the medical prognosis is good. Actually this policy is not always followed, and children have been brought back to health and returned to same situation that was at least partially responsible for the initial illness. A consideration of the intake policy in this connection is outside this present study. Occasionally, when over a long period of time the worker has been gradually able to build up a relationship with such a family, the point of view of the parents has modified, and the first steps in family casework has begun.

Now that it has been established that neither the Family Society nor the Catholic Charitable Bureau are interested in giving relief, such as a bed, or a stove, or clothing, in a family in which they are not doing casework, Children's Mission can be justified in providing such relief. The agency has perhaps been spending $15 a week board for a child

six to eight months or more in a medical home. If the child goes home to a cold house, or to share a bed with one or two siblings, and subsequently catches a cold as a result of these unhygienic conditions which brings on a recurrence of rheumatic fever, the previous large expenditure of money has been wasted. It would seem to be a good investment for the Mission to provide the necessary stove or extra bed. Too many times a child returns to the agency for another long placement because conditions at home were conducive to a recurrence of the disease. Perhaps one believes that public agencies should take care of such needs. The fact remains that not all public agencies do give this type of relief unless the family is receiving maintenance, and the need is left unsatisfied.

Careful consideration should be given to those cases in which it appears that relief will need to be given for a long time. D3 is an example of such a family. All other resources, both public and private, should be thoroughly explored, and if then it seems advisable for Children's Mission to remain in over an extended period, a very clear interpretation of the agency role should be given the family. There are situations in which regular supplementary aid may well be given in the home, rather than paying board for the child in a foster home. This has been done in the past, although it did not happen to occur in any case during the year studied.

It is the practice in the agency at the present time in recording, to make a statement of the plan at the end of the investigation in regard to medical procedure to be followed, and to present a medical diagnosis at the beginning of treatment. For the purpose of clarifying the thinking of the worker, and to make the record more useful for supervision, in referral to another worker when this is necessary, and for research purposes, the suggestion is made that a social diagnosis be made before the statement of plan at the close of the investigation, and that the plan include not only the medical care and follow-up required, but a social plan as well. It would be well for another social diagnosis to be made when foster home placement is about over, in order to establish the need for carrying the case SH, or to indicate there is no such need. If it is to continue SH, another plan should be stated at this point.

The data obtained in this study would indicate, in the writer's opinion, that by far the majority of cases carried by Children's Mission require no family casework. However, the workers should feel free to go into any family problems that are brought to them and that under other circumstances might be handled by a family agency.

Unless there is a radical change in policy of intake at Children's Mission, the emphasis will continue to be on the medical care of children. This, as has been seen, will re-

quire a great deal of activity on the part of the workers in visits to homes, foster homes, hospitals, and clinics, and in meeting the emergencies that constantly arise when the health of a child is concerned. Medical social workers, who are familiar with the clinic and hospital side of the story, or workers with child placing experience would probably bring most to the agency and adjust most quickly to its work. Since family casework represents generic casework, the foundation of the training of all social workers, no special experience in the family field seems needed for the handling of whatever family casework may be necessary.

Approved,

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# APPENDIX

# APPENDIX

# APPENDIX A - SCHEDULES

## SCHEDULE A

Used to furnish data on which to classify cases:

NAME CASEWORKER

REFERRED BY

DIAGNOSIS and NEEDS

REASON PLACEMENT IS REQUESTED

Description of home situation including family constellation

Classify according to (a) Health needs special care; (b) Home o.k. for child in normal health; (c) Emergency home crisis; (d) Long-time family problems

NUMBER OF AGENCIES INDEXED

Indicate if a family agency is indexed with dates active

DATES CASE SH

Summarize casework during this period

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Indicate if a family agency is indexed with dates active

DATES CASE SH

Summarize casework during this period

SCHEDULE B

Used to serve as a basis for analysing cases studied in full:

GROUP

NAME and AGE

NUMBER OF AGENCIES INDEXED

List of family agencies and dates active

REFERRED BY

Date

DIAGNOSIS

NEEDS

DESCRIPTION OF HOME IF IMPORTANT

FAMILY

PLACEMENT

Date

Work with child in foster home setting

Work with family

Cooperation with other agency

REFERRED TO PARENTS SH

Dates

Casework during SH

DISCHARGED and EVALUATION OF CONTACT BY WORKER

## SCHEDULE B

Used to serve as a basis for analyzing cases studied in full:

GROUP

NAME and AGE

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Date

List of family agencies and dates active

DIAGNOSIS

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Work with child in foster home setting

Work with family

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Casework during BH

DISCHARGED and EVALUATION OF CONTACT BY WORKER

## APPENDIX B

## AN ACT RELATIVE TO THE EDUCATION OF CERTAIN PHYSICALLY HANDICAPPED CHILDREN

Be it enacted, etc., as follows:

Chapter seventy-one of the General Laws is hereby amended by striking out section forty-six A, as amended by chapter one hundred and fifty-nine of the acts of nineteen hundred and thirty-two, and inserting in place thereof the following section:--Section 46A. The school committee of every town shall annually ascertain, under regulations prescribed by the department, after consultation with the commissioners of public health and public welfare, the number of children of school age and resident therein who are physically handicapped. In any town where, at the beginning of any school year, there is a child of school age resident therein so physically handicapped as to make attendance at a public school not feasible, and who is not otherwise provided for, the school committee shall employ a teacher or teachers, on full or part time, who shall, with the approval in each case of the departments of education and public health, offer instruction to each child in his home or at such place and under such conditions as the committee may arrange.

If a town furnishing instruction under this section to a child confined in a hospital, sanatorium or similar institution located therein is not the legal residence of the parent or guardian of such child, the town where such parent or guardian has a legal residence shall pay tuition to the town furnishing such instruction. Said tuition shall be computed at the regular rate established for non-resident pupils by the school committee of the town furnishing the instruction, filed with and approved by the department.

Approved June 28, 1945.

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Approved June 29, 1945.

# APPENDIX C

## DIRECTIONS FOR CARE OF RHEUMATIC FEVER CHILDREN IN UP-HOMES

### GENERAL INFORMATION ON RHEUMATIC FEVER

Prepared by Benedict F. Massell, M. D. for use in Children's Mission foster homes.

# DIRECTIONS FOR CARE OF

# RHEUMATIC FEVER CHILDREN IN UP-HOMES

1. First in importance is the protection of the children against upper respiratory infections which can cause recurrences of rheumatic fever. All other treatment is wasted if a cold or sore throat causes a flare-up of the children's illness. Of course it is not always possible to prevent colds and sore throats, but every effort should be made to do the utmost in this direction. No one with a respiratory infection should be allowed near the children. Everyone, including the house mother herself, her helpers, the school teacher, the parents, and other visitors, the social worker, and the attending physician should be aware of this. If one child gets a cold, sore throat, or unexplained fever, he should be kept by himself so that the infection will not spread to other children in the home.

2. A sufficient and well-balanced diet is necessary to maintain the proper resistance to infection. This should contain, daily: meat or fish, eggs, cooked and raw vegetables, citrous fruits or tomato juice, and a quart of milk a day (only pasteurized should ever be used).

3. An adequate amount of sleep and rest will also aid resistance to infection. Directions for rest periods and the limitation of activity in each individual case should be strictly followed.

4. In order to aid the physician in making a diagnosis, whenever there is a cold, sore throat, or whenever children do not seem well, temperatures should be taken four times a day - in the morning, at noon, in the late afternoon (4:00 p.m.), and in the evening, and should be recorded on the Daily Record Sheet. A temperature rise may be the first sign of a respiratory infection, a streptococcal throat infection, or a rheumatic fever flare-up. Any unusual rise in temperature should be reported at once to the social worker.

5. With symptoms of a cold or sore throat, child should be kept in bed until the symptoms have disappeared (this does not apply to slight sniffles). Fluids should be given freely. If fever accompanies the symptoms, the social worker should be notified immediately. Privine .05 % (child's strength) may be used for nose drops.

6. Any possible rheumatic symptoms (joint pains, chorea, pain over the heart, abdominal pain, nosebleeds, and rash), should be reported to the social worker immediately. They should be recorded on the Daily Record Sheet.

7. In general, if there is any question about anything, please report it.

# DIRECTIONS FOR CARE OF

## RHEUMATIC FEVER CHILDREN IN UP-HOMES

The following are the recommended procedures in specific problems:

CONSTIPATION:

Child may go two days without bowel movement without any concern. After that, use casafru according to directions on the bottle, first being sure that there is no abdominal pain.
Laxatives should never be given routinely.
In cases of chronic constipation, mineral oil may be used early before breakfast or just before bed. Chocolate is constipating.

NOSEBLEEDS:

If the nose is bleeding freely, insert boric acid ointment or vaseline into each nostril: then press the soft part of the nose between thumb and fingers very tightly and squeeze for ten minutes by the clock. Keep the child sitting up rather than allowing him to lie down. If the hand holding the nose gets tired, start holding with the second hand before removing the first in order to avoid release of pressure.
If nosebleed does not stop following this treatment, it will be necessary to call the local doctor to pack the nose.
Following nosebleed, keep the nose lubricated night and morning with boric acid oitment for three or four days.

EARACHE:

Use a hot water bottle, and call social worker who will notify the Children's Mission medical director.

ACTIVITY:

Children up for 4 to 6 hours daily may exercise lightly to the point of fatigue. They may play such games as bean bag, soft ball, croquet, if under supervision to be sure they do not get tired. They may go for auto rides at discretion of social worker. For special privileges, social worker should consult medical director. Stairs are allowed once or twice a day if taken slowly. For children in non-medical homes swimming is permissable in salt water, or in fresh water if there is no possible danger of contamination, but there must be care to prevent chilling.

SUNBATHING:

Child should be exposed to the sun gradually, 10 or 15 minutes at first, before 11 and after 3; then increase 5 minutes a day until tanned. Even when well tanned, child should not become overheated. Sunburn can cause flare-up of rheumatic fever and must be avoided.

DENTISTRY:

Dental work may be started when a child is up 4 hours.

TONSILLECTOMY:

Child should stay in bed for a week following T & A and should be checked in 10 days.
He should be in isolation for 48 hours following stay in the hospital.

## REMINDER

Please get in touch with the social worker very promptly whenever any unusual physical symptoms appear. Whenever there is any sign of illness, temperature should be taken in the morning and around 4:30 p.m. if the temperatures are not being taken routinely. This is necessary in making a diagnosis and in determining what action to take.

## GENERAL INFORMATION ON RHEUMATIC FEVER

One attack of rheumatic fever does not confer an immunity. Instead, a child who once has had rheumatic fever is susceptible to further recurrences.

Although the exact cause of the initial attack and the recurrences of rheumatic fever is not known, it seems likely that respiratory infections (colds, sore throats, pharyngitis and tonsillitis) bring about the disease in some unknown way. Furthermore, there is a strong evidence that colds and sore throats can cause the disease only when there is an associated invasion of the respiratory tract with the hemolytic streptococcus. In some instances a streptococcal infection of the throat may produce fever without any symptoms of a sore throat or cold.

Since the presence of hemolytic streptococci in the throat can be determined only by certain special laboratory tests which are not practical to carry out in foster homes, every cold and sore throat, and every apparently unexplained fever no matter how slight, must be considered a potential danger.

If a cold, sore throat, or unexplained fever causes a flare-up of rheumatic fever, it usually does not do so immediately. Following the respiratory infection there is a latent period which varies from a few days to a month. If there is a recurrence of rheumatic fever, the child may suddenly become obviously ill. On the other hand, the onset of the rheumatic fever may be insidious and the manifestations may be so mild that they will be overlooked unless one is on the alert.

The manifestations of rheumatic fever may be one or all of the following:

FEVER may be very slight or may be high. It may run in cycles so that after a period of several weeks or more of normal temperature fever may begin and last for four or five days or longer only to be followed by another period of normal temperature. Therefore, in order to know whether or not a patient has fever, the temperature should be taken every day. Since fever is apt to reach its height in the late afternoon, it is especially important to take it at this time (3-4 p.m.).

REMEMBER

Please get in touch with the social worker very promptly whenever any unusual physical symptoms appear. Whenever there is any sign of illness, temperature should be taken in the morning and around 4:30 p.m. if the temperatures are not being taken routinely. This is necessary in making a diagnosis and in determining what action to take.

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JOINT PAINS may be very mild. Only occasionally are they severe and accompanied by swelling, redness, and tenderness.

CHOREA (St. Vitus' Dance) is an involuntary motion which one can usually recognize again once they have seen it.

PAIN OVER HEART or in front of the chest, ABDOMINAL PAIN, NOSEBLEEDS AND RASH are other manifestations which may be of rheumatic fever origin. Subcutaneous NODULES, FRICTION RUBS, and changes in the HEART MURMURS are signs which require a physician for their recognition.

Sometimes a child with active rheumatic fever may show nothing but pallor, and appearance of fatigue, failure to gain weight, or loss of weight.

It should be remembered that rheumatic fever is an important disease because it can cause permanent damage to the heart (although some individuals escape without heart disease). Furthermore, every recurrence of rheumatic fever may increase this damage. Secondly, it should be emphasized that rheumatic fever is a chronic disease. Once an attack has begun, it is unusual for it to subside in less than three months, and in some instances it may last many months.

Children's Mission to Children

July 1948